Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	No. 13-1301 HA
PAUL HURA, M.D.,	)	
Respondent.	)	

DECISION

We find no cause for discipline of Paul Hura, M.D.'s physician and surgeon license.

Procedure

Petitioner Missouri State Board of Registration for the Healing Arts filed a complaint on July 18, 2013 alleging cause exists to discipline the physician and surgeon license of Respondent Paul Hura, M.D. Dr. Hura filed an answer on August 23, 2013.

We held a hearing on December 12, 2013. The Board was represented by its attorney, Frank B. Meyers. Dr. Hura was represented by his attorney, Paul D. Cowing, and also appeared in person. The case became ready for decision on January 22, 2014, when the parties filed their respective briefs.

Findings of Fact

Background

1. Respondent Paul Hura, M.D. has been licensed by the State Board of Registration for the Healing Arts as a physician and surgeon since September 2007. His license is current and active and was so at all times relevant herein.

2. Dr. Hura is a hospitalist who practices at St. Joseph Medical Center in Missouri. A hospitalist practices inpatient medicine, providing general medical care for patients, or consultations for other physicians who might ask for help in a hospital setting.

3. On January 12, 2012, Patient C.P. was admitted to St. Joseph Medical Center. She was diagnosed as suffering from a stroke and stayed at the hospital until January 28, 2012.

4. Dr. Hura became Patient C.P.'s attending physician upon her admission and was the physician primarily responsible for her care and treatment.

5. Nurse Amanda Roland cared for Patient C.P. during her hospitalization.

6. Patient C.P.'s adult daughter, Barbara Kellerman, was a nurse who worked at St. Joseph Medical Center, but not in the unit where her mother was being cared for. Ms. Kellerman spent time with her mother throughout her mother's hospitalization.

7. St. Joseph Medical Center has a Medical Staff, Medical Records Policy and Procedure Manual. In the entry explaining recording of a history and physical, the manual provides that patients must receive a physical examination and it must be recorded.

8. The manual also addresses progress notes:

> Progress notes shall be written daily on all inpatients and will contain sufficient evidence that the attending physician is overseeing the care of the patient.[1]

[1] Petitioner's Exhibit C, p. 8.

According to the manual, the purpose of a progress note is to justify treatment, document the course and results of treatment, promote continuity of care among health care providers, and document complications. The manual does not specify that a physical examination must be performed in connection with entry of a progress note, nor require that a health care provider who enters a progress note with information gathered from a physical examination be the provider who gathered it.

Events of January 17, 2012

9. On January 17, 2012, Dr. Hura met with Nurse Roland, the nurse assigned to Patient C.P., and they discussed the patient. Nurse Roland is a reliable, veteran nurse who works on the telemetry floor and in the intensive care unit, and cares for the sickest patients in the hospital. Dr. Hura has worked with her for years and trusts her. She had physically examined Patient C.P. earlier in the day on January 17, 2012, and would have taken a report from the night shift nurse about the patient.

10. Nurse Roland told Dr. Hura that Patient C.P. had an absence of chest pain, nausea or vomiting, and that the heart and lung exams were unchanged. The nurse said that the patient still had a regular heart exam and that her lungs were "diminished."[2] She did not say that the patient had wheezes.

11. Dr. Hura checked the patient's telemetry reading[3] at the desk, and it indicated normal heart function.

12. Following his conversation with Nurse Roland, Dr. Hura sat at the desk and wrote a progress note on the patient. The note constituted one page. The top half of the page contained

[2] Tr. 27, 49.

[3] A telemetry reading provides electrical documentation of the heart function, rhythmicity and rate.

information already typed in and which had been collected and entered by other health care staff, including patient name, date of birth, age, weight, admission date, vital signs, fluid inputs and outputs, and labs. Dr. Hura hand-wrote the information on the bottom half of the page:

> Chief complaint clostridium difficile colitis, etc. Diarrhea continues; some cough too; no chest pain, no nausea, vomiting. Heart: Regular S1S2; Lungs: decreased air entry bilaterally without significant wheezes. Assessment plan: status post-ischemic CVA, rehab per therapist and case manager recommendation; CDD-treat; history of atrial fibulation, GI bleed, no systemic anticoagulation.[4]

[Emphasis added.] The underlined portion of the hand-written progress note, about Patient C.P.'s heart and lungs, is the main portion of the progress note at issue herein.

13. Dr. Hura initialed the progress note at the bottom of the page and wrote the date and time.

14. Dr. Hura based the information he wrote in the progress note about the patient's heart and lungs on the conversation he had just had with Nurse Roland, his review of the patient's medical record, his knowledge of the patient since her admission, and the patient's telemetry reading.

15. Dr. Hura did not physically examine the patient himself before writing the progress note. He was not required by hospital policy to physically examine the patient in order to write a progress note.

16. The progress note does not state the source of the information about the patient's heart and lungs, whether Nurse Roland, the patient's record, or some other source. Such sources of information are not typically indicated in a progress note.

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[4] See Petitioner's Exhibit A, p. 1; Tr. 23-24, testimony of Paul Hura, M.D. Dr. Hura's entry contains several symbols and abbreviations. We have paraphrased the entry to omit the symbols and most abbreviations, for ease of understanding.

17. Although Dr. Hura normally would have gone in to examine Patient C.P. after preparing the progress note, he had to leave the hospital immediately after completing it due to a health emergency involving his wife. He did not return to the hospital that day.

18. Two hours after writing the progress note, Dr. Hura phoned the hospital and spoke with Ms. Kellerman, Patient C.P.'s daughter, about the patient's condition and the plan for treatment. Dr. Hura apologized for not seeing Ms. Kellerman's mother. Dr. Hura also spoke with Nurse Roland, who updated him about the patient's condition. Dr. Hura gave Nurse Roland medication orders for the patient.

19. Dr. Hura called the hospital again about one and a half hours later to check on Patient C.P.'s condition. He gave Nurse Roland another order for the patient.

20. Because Dr. Hura did not see Patient C.P. on January 17, 2012, and based on his understanding of billing requirements, he did not bill for his services of January 17, 2012.

21. When he wrote his progress note on Patient C.P. on January 17, 2012, Dr. Hura did not intend for other health care providers to believe he had personally performed a physical exam of the patient. He did not knowingly or intentionally make a false statement.[5]

22. There is no evidence that Dr. Hura in any way compromised Patient C.P.'s care.

Conclusions of Law

We have jurisdiction. §§ 334.100.2 and 621.045, RSMo (Supp. 2012).

The State Board of Registration for the Healing Arts is an agency of the State of Missouri, created and established pursuant to section 334.120, RSMo (Supp. 2012), for the purpose of executing and enforcing the provisions of Chapter 334, RSMo.

When the Board files a complaint alleging cause for discipline exists, it bears the burden of proving such cause exists, *see Mo. Real Estate Comm'n v. Berger*, 764 SW2d 706, 711 (Mo.

[5] Tr. 40, testimony of Paul Hura, M.D.

App. E.D. 1989), and must do so by a preponderance of the evidence, *see State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo. App. W.D. 2000). This Commission must judge the credibility of witnesses, and we may believe all, part, or none of the testimony of any witness. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo. App. W.D. 1992). When there is a direct conflict in the testimony, we must make a choice between the conflicting testimony. *Id.*

Here, the Board alleges cause for discipline exists under § 334.100.2(4) and (14):

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> * * *
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> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including but not limited to, the following [17 non-exclusive grounds listed];
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> * * *
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> (14) Knowingly making, or causing to be made, or aiding, or abetting in the making of, a false statement in any birth, death or other certificate or document executed in connection with the practice of the person's profession[.]

[Emphasis added.]

The factual crux of the Board's complaint against Dr. Hura is the progress note he wrote on Patient C.P. on January 17, 2012, specifically, one line of the progress note: **"**Heart: Regular S1S2; Lungs: decreased air entry bilaterally without significant wheezes." The Board alleges

"the . . . progress note states that [Dr. Hura] performed a physical exam of Patient C.P.," which he did not in fact perform.[6]

The Board does not point to any of the 17 non-exclusive grounds for discipline listed under § 334.100.2(4). We therefore consider its claims of misconduct, misrepresentation, dishonesty, unethical conduct or unprofessional conduct thereunder to be based on its allegation that the progress note was false, which is also central to its claim under subsection (14). Accordingly, we will address subsections (4) and (14) of § 334.100.2 in reverse order.

As discussed below, cause exists under neither.

Subsection (14)—Knowingly making a false statement in a medical record

The Board alleges "the . . . progress note states that [Dr. Hura] performed a physical exam of Patient C.P.," which he did not in fact perform, and that he therefore knowingly made a false statement.[7, 8] We disagree, for several reasons.

Nowhere does the progress note explicitly state that Dr. Hura performed a physical exam, whether in the line to which the Board specifically points, nor anywhere else on the page. The Board's claim fails for that reason alone.

Even if we broadly read the Board's claim as, "the . . . progress note states, *in so many words*, that [Dr. Hura] performed a physical exam," we still conclude that the Board has failed to carry its burden of proof, for at least a few, separate reasons. First, in the instant context, "knowingly" means with awareness, deliberateness or intention. *Rose v. State Bd. of Regis'n for*

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[6] Complaint, p. 3, ¶ 9.

[7] *Id*.

[8] To be clear, the Board does not allege in its complaint that the information noted about the state of Patient C.P.'s heart and lungs was wrong or fabricated. A complaint establishes notice of the bases for discipline. 1 CSR 15-3.350(2)(A)1; *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo. App. E.D. 1984). We cannot find cause for discipline related to acts or omissions not charged in a complaint. *Dental Bd. v. Cohen*, 867 S.W.2d 295, 297 (Mo. App. W.D. 1993).

the Healing Arts, 397 S.W.2d 570, 577 (Mo. 1965). Dr. Hura testified that he did not knowingly or intentionally make a false statement.[9] We find him credible.

Second, the progress note is replete with information gathered from other sources in any event, and with which the Board has no quarrel. The top half of the progress note contains pre-printed information from sources other than Dr. Hura, including information about the patient's vital signs, labs, and fluid inputs and outputs. In addition to the line in Dr. Hura's hand-written entry to which the Board points—**"**Heart: Regular S1S2; Lungs: decreased air entry bilaterally without significant wheezes"—other parts he wrote also contain data he did not personally observe or obtain by physically examining the patient that day: "Diarrhea continues; some cough too; no chest pain, no nausea, vomiting."[10] If, as the Board alleges, the line **"**Heart: Regular S1S2; Lungs: decreased air entry bilaterally without significant wheezes" was intended by Dr. Hura to mean he had physically examined the patient even though he did not, the Board does not explain how the other parts of the progress note are any different in such respect, and we conclude they are not. The one sentence on which the Board relies—**"**Heart: Regular S1S2; Lungs: decreased air entry bilaterally without significant wheezes"—when examined in the context of the progress note as a whole, does not evidence the doctor's intent to make a false statement.

Finally, the St. Joseph Medical Center's policy manual, which the Board does not address in its briefing, significantly undercuts the Board's position. The manual provides that a record of a history and physical includes a physical exam, but a progress note need not. The manual does not provide that information gathered by physical exam and recorded in a progress note can only be recorded by the health care provider who performed the exam. In fact, the record shows that

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9 Findings of Fact, ¶ 21.

10 Petitioner's Exhibit A, p. 1.

it is not typical practice for a physician to specify his sources of information for making a progress note. Had the manual established, for example, that a progress note containing information gathered by physical exam must be made by the person performing the exam, or must identify the sources of the information if not, we may have viewed the Board's claim differently. But the manual, and in fact hospital practice, support the manner in which the doctor made the progress note here.

A wrinkle in the Board's case is that it made the factual allegation in its complaint[11] and maintains in post-hearing briefing[12] that Dr. Hura *only* based the information he noted about the patient's heart and lungs on his discussion with Nurse Roland. The Board then points to aspects of the progress note concerning the patient's heart and lungs that, the Board argues, the nurse would not have provided to the doctor[13], apparently to suggest that the information about Patient C.P.'s heart and lungs was wrong or fabricated. Inasmuch as the Board's theory in this case is that Dr. Hura made a false entry in a progress note indicating he performed a physical exam, and *not* that information in the progress note (concerning the patient's condition) was wrong or fabricated, we fail to see how the point is germane.[14, 15]

Dr. Hura did not knowingly make a false statement in a medical record. There is no cause for discipline under § 334.100.2(14).

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[11] Complaint, ¶ 8.

[12] Petitioner's Proposed Findings of Fact, Conclusions of Law and Argument, pp. 2-4, ¶¶ 5-25 (Proposed Findings of Fact), and p. 11 (Argument).

[13] *Id*.

[14] See footnote 8, above.

[15] We disagree with the Board in any event. The record does not demonstrate that the information was wrong. And we found that Dr. Hura based the information he wrote about the patient's heart and lungs not only on the conversation he had had with Nurse Roland, but on his review of the patient's medical record, his knowledge of the patient since her admission, and the patient's telemetry reading. Finding of Fact, ¶ 14. Had the Board properly made a claim that the information in the progress note concerning the patient's condition was wrong or fabricated, the Board would have failed to bear its burden of proof.

Subsection (4)—Misconduct, misrepresentation, dishonesty, unethical conduct or unprofessional conduct

In view of our above conclusion with respect to § 334.100.2(14), disposition of the Board's allegations under § 334.100.2(4) is simple. We reject each of the specific grounds the Board raises: misconduct, misrepresentation, dishonesty, and unethical or unprofessional conduct.

In the context of professional licensure and discipline, Missouri courts define "misconduct" as "the willful doing of an act with a wrongful intention." *See Duncan v. Mo. Bd. for Architects, Professional Engineers and Land Surveyors*, 744 S.W.2d 524, 541 (Mo. App. E.D. 1988).

In a proceeding under § 334.100, the Court of Appeals defined "misrepresentation" as "a falsehood or untruth made with the intent of deceit rather than inadvertent mistake." *Hernandez v. State Bd. of Regis'n for the Healing Arts*, 936 S.W.2d 894, 899 n.3 (Mo. App. W.D. 1997).

Dishonesty is the "disposition to defraud, deceive, or betray." WEBSTER'S THIRD NEW INT'L DICTIONARY UNABRIDGED 650 (1986).

The definitions of unethical and unprofessional conduct overlap. The terms include "any conduct which by common opinion and fair judgment is determined to be unprofessional or dishonorable." *Perez v. Mo. Bd. of Regis'n for the Healing Arts*, 803 SW2d 160, 164 (Mo. App. W.D. 1991). In *Boyd v. State Bd. of Regis'n for the Healing Arts*, 916 S.W.2d 311, 314-315 (Mo. App. E.D. 1995), an unlicensed physician failed to complete the licensure portions of her Medicare and Medicaid applications, and another person added in statements that were false, but the doctor did not know the person would do so. The court held that the physician's actions may have been careless, but she did not knowingly make a false statement and could not be disciplined for committing unethical and unprofessional conduct. *Id*. at 315.

Dr. Hura did not knowingly make a false statement in a medical record. Accordingly, he did not willfully do an act with a wrongful intention (commit misconduct). Nor did he state a falsehood or untruth with the intent of deceit (make a misrepresentation), or display a disposition to defraud, deceive, or betray (demonstrate dishonesty). His conduct was not unprofessional or unethical because, like the physician in *Boyd*, he did not knowingly make a false statement.

There is no cause for discipline under § 334.100.2(4).

Summary

No cause for discipline exists under § 334.100.2(4) or (14).

SO ORDERED on January 28, 2014.

\s\ Alana M. Barragán-Scott
ALANA M. BARRAGÁN-SCOTT
Commissioner